Prospective Payment System (PPS)

Program Review and Evaluation

Health Budgets and Financial Policy

OASD(Health Affairs)

Resourcing the Direct Care System for Value

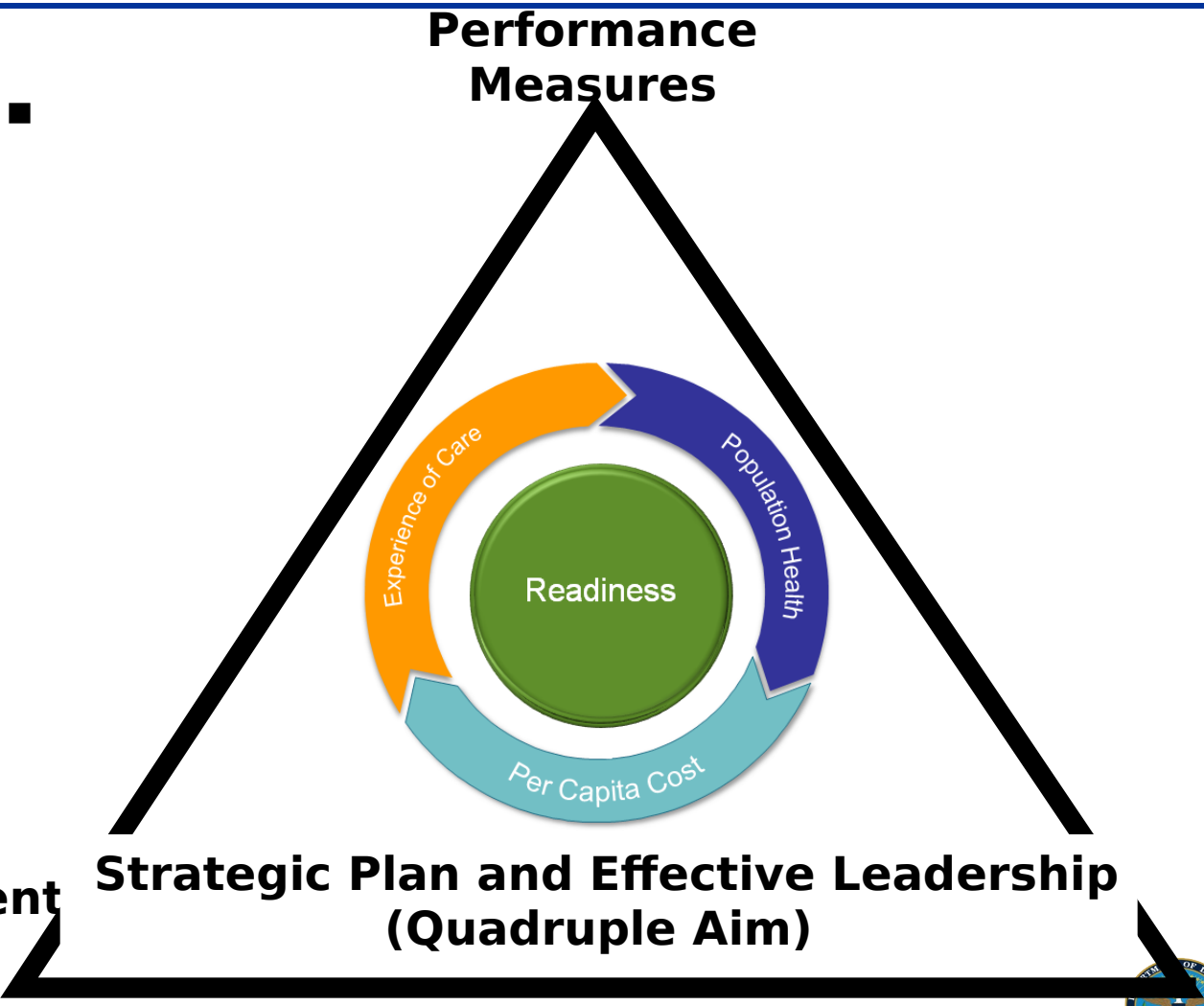
The Direct Care System (DCS) is the heart of military medicine and provides:

- a ready to deploy medical capability
- a medically ready force
- delivery of the health benefit to warriors and their families

..but at the appropriate value?

$$\frac{\text{Outputs (Activities)} + \text{Outcomes (Readiness, Population Health)} + \text{Customer satisfaction}}{\text{Resources (MilPers, appropriations, reimbursements)}}$$

Creating Breakthrough Performance in the MHS



Each Element is essential.

Agenda

- Current PPS Production and Valuation
  - How PPS values production
  - Changes for FY10
  - External Workload reporting
  - FY10 Rates
  - Rebase, Program and Workload Guarantee
- *CMS RVU Review/Adjustment (?)*
- Performance Based Planning
- Issues for Consideration in Data Quality

PPS Value of Care

- Value of MTF Workload
  - Fee for Service rate for workload produced
- Rates based on price at which care can be purchased
  - TMAC rates
  - Not MTF costs
- Computed at MTF level but allocated to services
  - Rolled up to Services

TMAC versus PPS

Civilian

- Inpatient
  - Institutional
    - Hospital (MS-DRG)
      - Including ancillaries, pharmacy
  - Professional (RVU)
    - Surgeon
    - Anesthesiologist
    - Rounds
    - Consultants
- Outpatient
  - Professional (RVU)
  - Institutional (APC)
- Outpatient Ancillary
  - (RVU/Fee Schedule)

Direct Care PPS

- Inpatient (RWP, i.e. MS-DRG)
  - All Institutional and Professional
    - Hospital
      - Including ancillaries, pharmacy
    - Surgeon
    - Anesthesiologist
    - Internist
    - Consultants
- Outpatient
  - Professional (RVU)
  - Institutional (APC)
    - Emergency Room and Same Day Surgery
- Outpatient Ancillary (Pass Thru)
  - None

Workload Measure Changes to PPS for FY10

- Move to MS-DRG from DRG
- Change from Simple Work RVU only to Enhanced Work + NonFacility Practice RVU
- Addition of APCs for facility

DRG Comparison

- Historical DRG
  - System to classify hospital cases into one of approximately 500 groups
  - System in use since approximately 1983, with minor updates on a yearly basis
  - Calculated for TRICARE using CMS method just for our beneficiaries with-in Purchased Care claims
- MS-DRG – Severity Adjusted DRGs
  - System used to differentiate levels of complexity for the DRGs
  - Approximately 750 different groups
  - CMS implemented in 2008
  - TRICARE implemented in 2009

Potential Impact of moving to MS-DRG

- Comparison of Rolling 12 information using both old DRG, and new MS-DRG to an FY07 baseline
- If we had used MS-DRGs, all Services would have seen a net increase

RWP vs MS-DRG RWP (MS-DRG Accepted last meeting)					Service
	RWP Diff	RWP Value Diff	MS-RWP Diff	MS-RWP Value Diff	Net Difference
Army	253	$ 7,585,554	1,142	$ 18,391,215	$ 10,805,661
Navy	(3,799)	$ (39,720,559)	(2,952)	$ (31,785,796)	$ 7,934,763
Air Force	(772)	$ (5,356,616)	(157)	$ 1,763,988	$ 7,120,604

RVU comparison

- Old Method
  - Uses Work RVU for all payments
    - Work RVU only represents provider portion
  - Payments based on Product Lines
    - Defined by MEPRS codes
    - Significant variation in rates ($38/RVU to $330/RVU)
    - Rates based on Allowed Amount from Purchased Care claims divided by Work RVUs
- New Total RVU method
  - Uses both Work and Practice RVUs for payments
    - Practice RVU represents the cost of the staff/office/equipment
  - Provides appropriate credit for equipment intensive procedures
  - Allows for a Standard Rate per RVU
    - Can use same rate as Purchase Care
  - Used with Ambulatory Payment Classification (APCs)
    - Facility charges now available for ER and Same Day Surgery
    - Consistent with TRICARE change for CY09

Geographic Practice Cost Index (GPCI)

- Based on Medicare locality Adjustments
- Different rates for Work and Non-Facility Practice
  - Work
    - Generally 1.0 +, max 1.5 for Alaska
  - Non-Facility Practice
    - Range 0.803 (part of Missouri) to 1.342 (part of California)
- Payment Amount
  - Multiply the RVU for each component times the GPCI for that component

Expansion of PPS for External Workload

- Valuation to began in FY2008
  - All reporting will be considered “new” workload
  - Standardized reporting method across Services
- External Partnerships (5400) and VA facilities (2000)
  - Differentiate Professional Service vs Facility Charges
- Payment based on Total RVU
  - Enhanced (Work + Facility Practice)
  - Standard Rate similar to CMS
    - Not Product Line specific – FY10 same as all RVUs
  - Professional Providers only
  - MEPRS A & B codes only
- Still must solve DoD Circuit Rider workload reporting

Current PPS Workload

- Inpatient – MEPRS A Workcenters
  - Non-Mental Health – Severity Adjusted DRGs Relative Weighted Products (RWPs)
  - Mental Health - Bed Days
- Outpatient – MEPRS B Workcenters
  - Enhanced Work + Practice Relative Value Units (RVUs)
    - Excluding Generic Providers and Nurses
  - Ambulatory Payment Classification (APCs)
    - Facility charges now available for Emergency Room (ER) and Same Day Surgery (SDS)
    - Consistent with TRICARE change for CY09

Valuing MHS Workload
Fee for Service Rates FY10 (FY11)

- Value per MS-RWP - $9,107 (MEPRS A codes) FY11 ($9,535)
  - Average amount allowed
    - Including institutional and professional fees
    - Excluding MH/SA
    - Adjusted for local Wage index and Indirect Medical Education Adjustment (IME)
- Value per Mental Health Bed Day - $769 (MEPRS A codes)
  - FY11($823)
  - Average amount allowed
    - Including institutional and professional fees
    - Adjusted for local Wage index and Indirect Medical Education Adjustment (IME)
- Value per RVU - $36 (MEPRS B codes) FY11 (37.43)
  - Standard Rate – like TMAC/CMS
    - Excluding Ancillary, Home Health, Facility Charges (except ER/SDS)
    - Adjusted for local geographic price index both Work and Practice
- Value per APC - $66 (MEPRS B codes ER/SDS) FY11 (68.86)
  - Standard Rate

Two Rebaselining Issues

- Rebaselining for current performance
- Adjusting PPS targets for programmatic adjustments

Rebaselining current performance

- Move from FY07 to FY09 baseline
- Recognize current performance in programmed budget
- This accounts for system changes in past couple of years
- Adjust outyear targets to current performance

Adjusting PPS targets for programmatic adjustments

- Dollars have been added/subtracted from service budgets based on projected changes in health care requirements resulting from line endstrength changes
- PPS baselines need to be adjusted to reflect the anticipated and already budgeted for change in workload
- Service Agreements for production improvements, instead of prior POM adjustments

Moving from budget to PPS workload

- Adjust target based on dollar budget adjustment
  - 807700 O&M plus MILPERS adjustments
  - Must take into account that PPS is not complete
- Apply percentage ratio
  - Program was adjusted based on MEPRS based full cost and claims of providing care to AD and ADFM
  - Use total non-pharmacy MEPRS cost as denominator and PPS value as numerator

POM and Target Impacts including Programmatic with Lag

	POM Adjustment in Millions			
	Army	Navy	AF	
FY03/07 Net Workload Change	$ 103	$ (33)	$ (53)	$ 17
Workload Increase Commitment	$ -	$ 33	$ 46	$ 79
FY10 POM Adjustment	$ 103	$ -	$ (7)	$ 96
FY09 Programmattic Adjustment (Already Adjusted in POM)	$ 294	$ 4	$ (63)	$ 236
PPS Earnings to MEPRS A/B less Rx ratio	81%	72%	60%	
PPS Adjustment for Programmatic Changes FY09	238	3	(38)	$ 204
Adjusted FY10 Target	$ 238	$ 36	$ 8	$ 283

All dollars are FY08 and must be inflated for FY10 execution

FY 2010 PPS Budget Adjustment

- Military Personnel
  - PPS value includes work produced with military personnel
  - However, MilPers is not in the DHP in year of execution

O&M Factor

	FY 10
Army	69%
Navy	52%
AF	35%
Total	55%

- Adjustment =

  O&M Adjustment *

  (Difference between Most Recent 12 Months Value and FY09 Workload Valued at FY2010 Rates)

- Note: Changed Baseline Year from 2007 to 2009

FY10 Mid Year Summary

	RVUs				APCs			RWPs			Mental Health Days		
	FY09	Rolling 12	FY10 Plan	FY09	Rolling 12	FY10 Plan	FY09	Rolling 12	FY10 Plan	FY09	Rolling 12	FY10 Plan
Army	30,177,999	31,412,270	31,015,010	4,267,545	4,289,766		105,768	105,454	108,887	39,417	38,661	41,064
Navy	18,169,333	18,705,232	17,694,038	2,222,398	2,152,279		54,598	54,951	54,779	21,479	21,931	20,337
Air Force	13,544,108	13,797,703	13,771,202	1,416,849	1,405,760		33,936	34,200	33,218	4,717	4,982	6,469
MHS	61,891,440	63,915,205	62,480,251	7,906,792	7,847,806		194,302	194,605	196,884	65,613	65,574	67,869

PPS Earnings				
FY09		Rolling 12		FY10 Plan
2,722,978,025		2,762,136,291		2,725,352,724
1,521,737,649		1,540,681,378		1,479,118,546
1,021,718,922		1,033,455,362		1,015,206,422
5,266,434,597		5,366,733,040		5,219,677,692

FY05 (Millions $)

Adjusment	Plan	Mid Year Total
Army	30.6	8.4
Navy	2.2	4.1
Air Force	(2.5)	(4.4)
Total	30.3	8.1

FY06 (Millions $)

Adjustment	Plan	Mid Year
Army	15.4	2.5
Navy	17.3	2.9
Air Force	(16.4)	(20.0)
Total	16.3	(20.4)

FY07 (Millions $)

	Adjustment in Millions
Army	29.2
Navy	(17.1)
Air Force	(20.9)
Total	(8.8)

FY08 (Millions $)

	Millions	
Adjustment	Rolling 12	Plan
Army	20.1	(36.3)
Navy	(9.4)	40.2
Air Force	(6.2)	(57.6)
Summary	4.5	(53.7)

Summary for Performance

Summary Performance	In Millions of Dollars			
	Army	Air Force	Navy	MHS
Workload				
Current Recon (Army Adj)	$ (4.646)	$ (15.970)	$ (21.416)	$ (42.032)
TBI/PH Workload Requirement	$ (48.298)	$ (1.868)	$ (10.182)	$ (60.347)
Radiology FY08-09 (Inc O&M adj)	$ 12.566	$ 2.185	$ 6.313	$ 21.063
Summary Workload	$ (40.377)	$ (15.653)	$ (25.286)	$ (81.316)
HEDIS Performance Award	$ 13.078	$ 7.332	$ 8.366	$ 28.775
Workload + Performance Award	$ (27.300)	$ (8.322)	$ (16.920)	$ (52.541)
Army POM Funding Shortage	$ 42.179			$ 42.179
Net Adjustment	$ 14.880	$ (8.322)	$ (16.920)	$ (10.362)

CMS RVU Review/Adjustment

- 5 year review of RVUs
- For CY07 significant change in work RVUs
- Adjusted to emphasize Patient Doctor interaction
- Result in higher RVU for most E&M codes
- Did not dramatically reduce codes for specialists
- However, must have balanced budget
  - Budget Neutrality Factor reduction
  - RVUs multiplied by 0.8994

Impact of Work RVU change on MHS

CY06 MEPRS-B SADR freqs pulled 2/2/2007 from MDR by PPS/BP Product Line
Work RVUs based on MHS Master RVU tables for CY06 and CY07

	Data			
PPS/BP Product Line	**Sum of CPT COUNT***	**Sum of CY06 Work RVU*Count**	**Sum of CY07 Work RVU* Count**	**% Change from CY06**
DERM	531,795	382,860	410,653	7.3%
ENT	402,139	382,329	420,762	10.1%
ER	3,092,846	1,710,620	2,089,619	22.2%
IM SUB	3,400,834	1,693,588	1,815,849	7.2%
MH	3,701,697	2,787,843	2,831,958	1.6%
OB	2,976,090	1,734,160	1,958,748	13.0%
OPTOM	4,482,029	2,215,681	2,228,524	0.6%
ORTHO	9,027,337	3,221,644	3,360,728	4.3%
OTHER	2,657,843	945,825	989,846	4.7%
PC	21,306,231	11,319,846	13,311,193	17.6%
SURG	529,735	492,782	532,388	8.0%
SURG SUB	494,374	413,021	459,713	11.3%
OTH	4,049	3,445	3,934	14.2%
Grand Total	52,606,999	27,303,646	30,413,915	11.4%

*Includes only CPT codes appearing in both CY06 and CY07 Master RVU tables

Issue of Budget Neutrality Factor

CY06 MEPRS-B SADR freqs pulled 2/2/2007 from MDR by PPS/BP Product Line
Work RVUs based on MHS Master RVU tables for CY06 and CY07

	Data				CMS Adj factor = 0.8994	
PPS/BP Product Line	Sum of CPT COUNT*	Sum of CY06 Work RVU*Count	Sum of CY07 Work RVU* Count	% Change from CY06	CY07 Adjusted	% Change from CY06
DERM	531,795	382,860	410,653	7.3%	369,341	-3.5%
ENT	402,139	382,329	420,762	10.1%	378,434	-1.0%
ER	3,092,846	1,710,620	2,089,619	22.2%	1,879,403	9.9%
IM SUB	3,400,834	1,693,588	1,815,849	7.2%	1,633,174	-3.6%
MH	3,701,697	2,787,843	2,831,958	1.6%	2,547,063	-8.6%
OB	2,976,090	1,734,160	1,958,748	13.0%	1,761,698	1.6%
OPTOM	4,482,029	2,215,681	2,228,524	0.6%	2,004,334	-9.5%
ORTHO	9,027,337	3,221,644	3,360,728	4.3%	3,022,639	-6.2%
OTHER	2,657,843	945,825	989,846	4.7%	890,268	-5.9%
PC	21,306,231	11,319,846	13,311,193	17.6%	11,972,087	5.8%
SURG	529,735	492,782	532,388	8.0%	478,830	-2.8%
SURG SUB	494,374	413,021	459,713	11.3%	413,466	0.1%
OTH	4,049	3,445	3,934	14.2%	3,538	2.7%
Grand Total	52,606,999	27,303,646	30,413,915	11.4%	27,354,275	0.2%

*Includes only CPT codes appearing in both CY06 and CY07 Master RVU tables

Expanding Pay for Performance to Match the Vision

- Premise: MHS Value is predicated on three elements
  - Outputs - the volume of work that we accomplish, measured currently by RVUs/APCs and RWPs/Bed Days
    - Incomplete
  - Outcomes – often measured via factors such as HEDIS/JCAHO
  - Customer Satisfaction
- Our focus to date has been centered on productivity (Outputs) as the MHS source of value for the Department.

- Goal: Create a financial mechanism for the direct care system that will emphasize value measures for outcomes and customer satisfaction in a balanced fashion with outputs

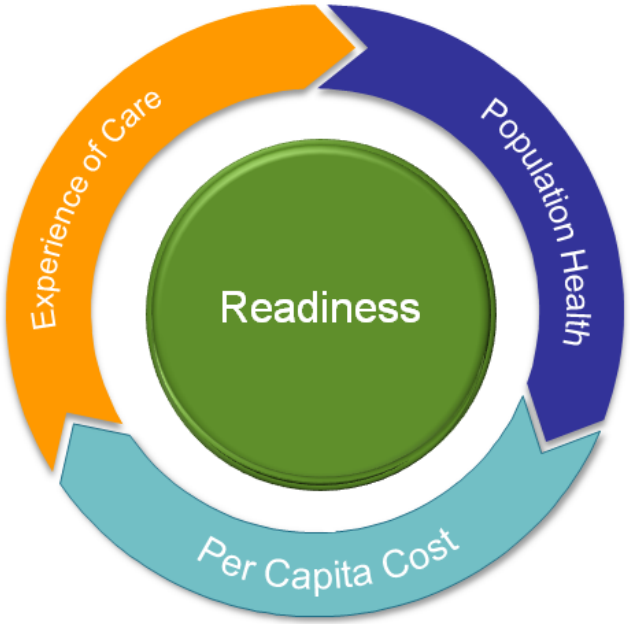
Performance Planning Integrated Project Team

- The Joint Health Operations Council (JHOC) chartered a Performance Planning Integrated Project Team (IPT)
  - Create a revised incentive structure and planning approach aligned with the Quadruple Aim
  - The approach encompasses the total beneficiary population
    - Direct and Purchased
    - Prime, Standard
  - Piloted at six sites in 2010.

Recap – The Quadruple Aim

Readiness
Ensuring that the total military force is medically ready to deploy and that the medical force is ready to deliver health care anytime, anywhere in support of the full range of military operations, including humanitarian missions.

Experience of Care
Providing a care experience that is patient and family centered, compassionate, convenient, equitable, safe and always of the highest quality.



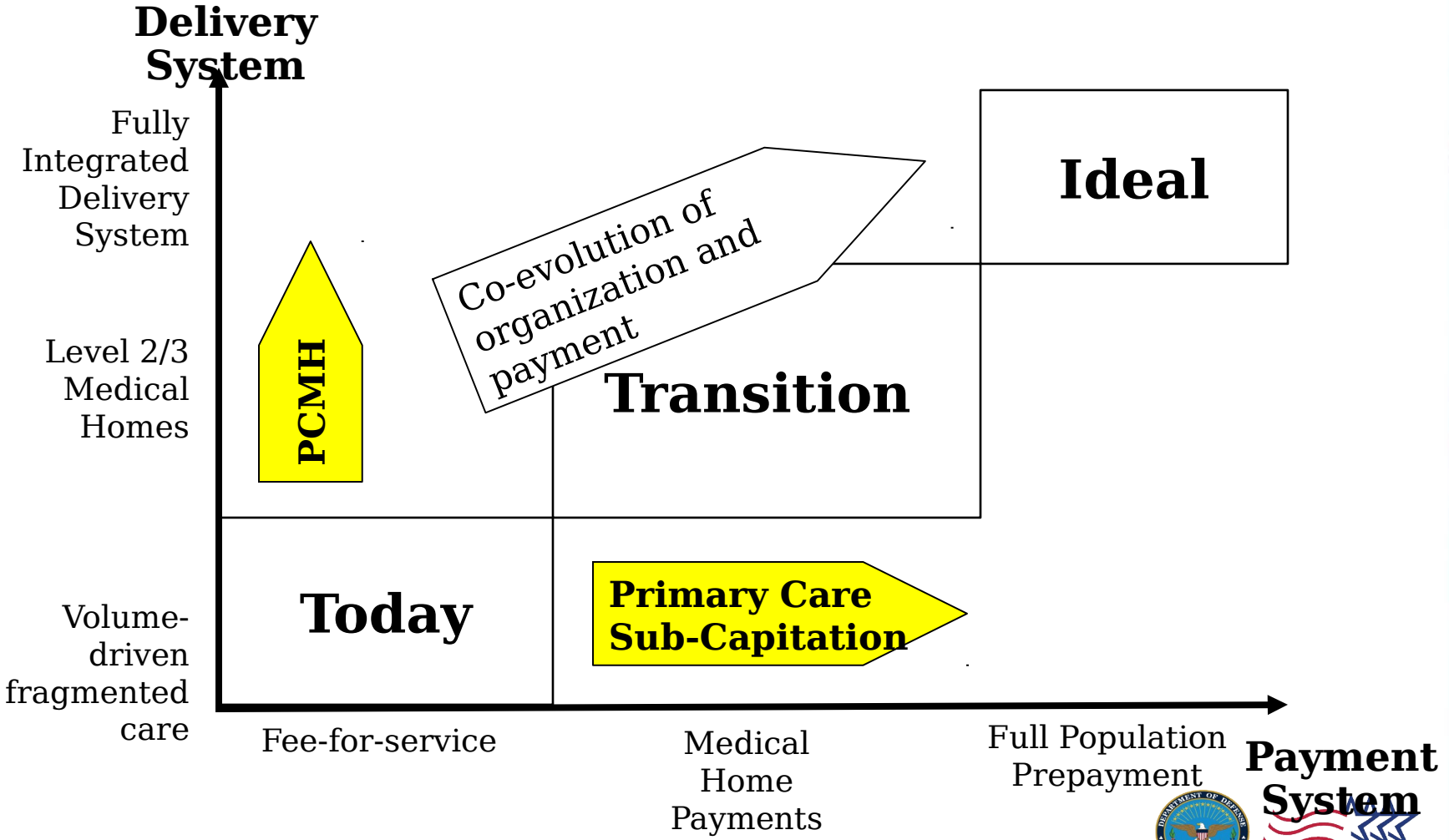
Population Health
Improving the health of a population by encouraging healthy behaviors and reducing the likelihood of illness through focused prevention and the development of increased resilience.

Per Capita Cost
Creating value by focusing on quality, eliminating waste, and reducing unwarranted variation; considering the total cost of care over time, not just the cost of an individual

Incorporating the Quadruple Aim in PPS

- For PPS, incorporating the Quadruple Aim involves two changes:
  - Consider changes in the way we measure health care that will incentivize lower per capita costs
  - Consider adjustments based on performance in experience of care and population health
  - Incorporate measures for readiness

Transition In Both Payment and Delivery Systems



Adapted From "From Volume To Value: Better Ways To Pay For Health Care", Health Affairs, Sep/Oct 2009.

Value-Based Incentive Design Plan – Summary

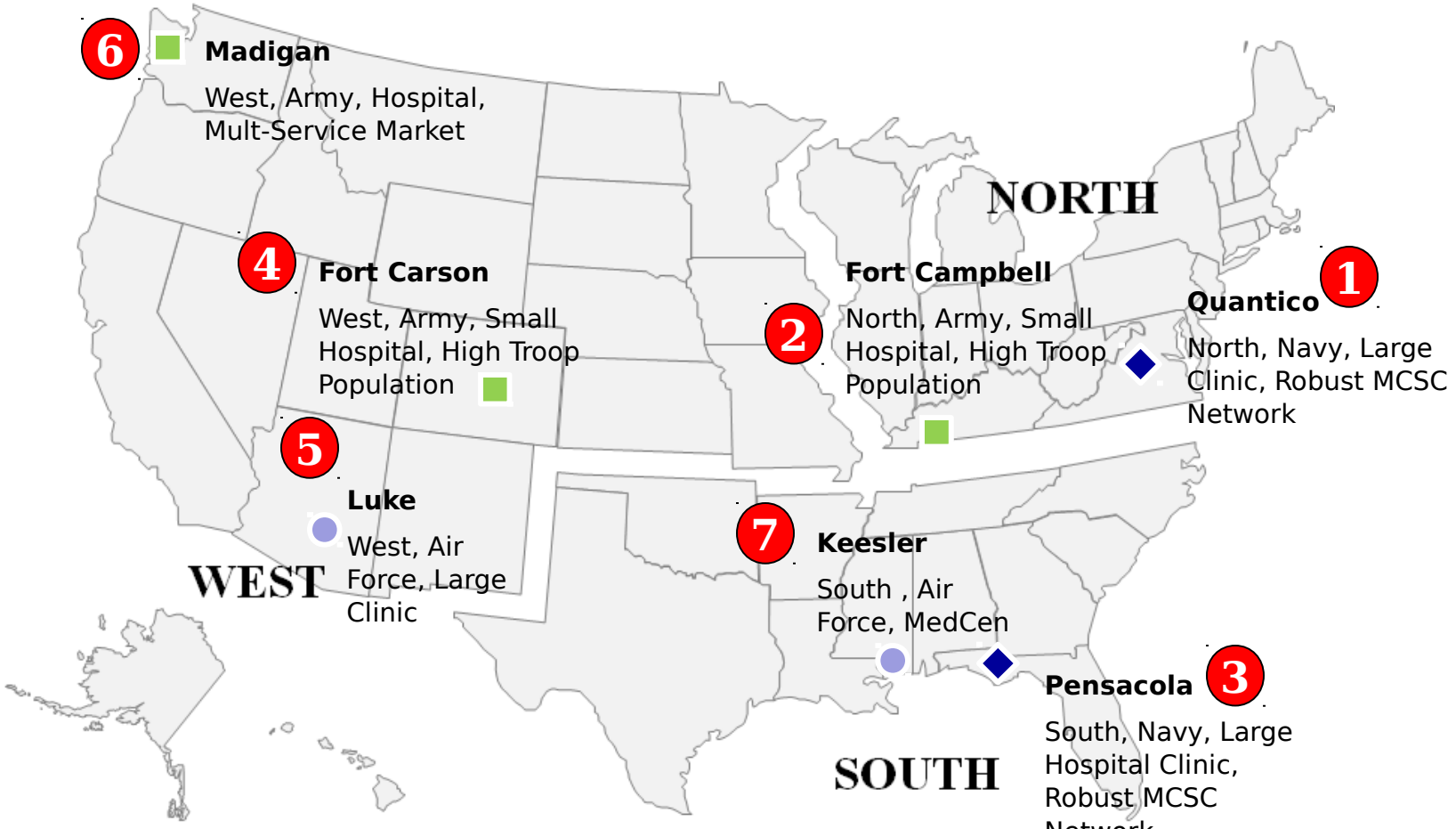
Last Updated: 10 FEB 10

Activity		Funding Approach for MTFs			Primary Impact on Quadruple Aim				MCSC AFB Adjustment	Primary Impact on Quadruple Aim			
Note: The Year 1 Performance Planning IPT Pilots will focus on Activities 1,3,4,5,8,9,10. The pilots may incorporate improvement efforts and other ideas for activities 2,6,7, but the intent is not to include them in the design of incentives and rewards.		*Direct Payment*		*Adjustment*	*Readiness*	*Population Health*	*Experience of Care*	*Per Capita Cost*	*Note: On a quarterly basis, the Award Fee Board (AFB) uses input from MTF commanders, beneficiary satisfaction surveys, MCSCs, and TROs to make a recommendation to the Award Fee Determination Official what percentage of the amount set aside for the award should be given to the MCSC.*	*Readiness*	*Population Health*	*Experience of Care*	*Per Capita Cost*
1	**Readiness**	(FFS Rate) X (No. of Dental Services and PHAs)	+/-	Reducing Rate of Indeterminate IMR	X	X			N/A				
2	Wellness	TBD	+/-	TBD	X	X	X	?	TBD	X	X	X	?
3	**Prevention**	(FFS Rate) X (No. of Preventative Services)	+/-	HEDIS (Breast Cancer Screens; Colorectal Cancer Screens; Cervical Cancer Screens; Well-child Visits)		X		?	HEDIS (Breast Cancer Screens, Colorectal Cancer Screens; Cervical Cancer Screens)		X		?
4	**Primary Care**	(FFS Rate) X (Primary Care RVUs Including Virtual Visits)	+/-	Satisfaction, Access, Continuity, Use of "Outsourced" Care; HEDIS (Asthma, Diabetes, Behavioral Health)			X	X	PCM Continuity, Decreased ER Utilization, HEDIS (Asthma, Diabetes, Behavioral Health)			X	X
5	**Operating as a PCMH**	(Tiered Per Enrollee PCMH Bonus) X (No. Enrollees at Each PCMH Level)	+/-	None	X	X	X	X	TBD	X	X	X	X
6	Caring for Specific Populations – Episodic Conditions	(Episodic Rate) X (No. Episodes)	+/-	Episode Outcomes TBD			X	X	TBD			X	X
7	Caring for Specific Populations – Chronic Conditions	(Bundled Rate) X (No. Chronic Disease Enrollees)	+/-	Health Outcomes TBD			X	X	TBD			X	X
8	**Other Specialty Care**	(FFS Rate) X (No. of Ambulatory RVUs)	+/-	Decrease in un-appointed referrals, Coordination of Care	X		X	X	Decrease in un-appointed referrals	X		X	X
9	**Inpatient Care**	(FFS Rate) X (No. of Inpatient RWPs)	+/-	ORYX, GME, Patient Safety, Decrease in un-appointed referrals, Coordination of Care	X		X	X	Decrease in un-appointed referrals	X		X	X
10	**Management of PMPM**	None	+/-	Overall Management of PMPM				X	Overall Management of PMPM				X

Notes

- The objective of the Performance Planning pilots is to focus MTR and TRO plans on what can be done to improve performance as it relates to the Quadruple Aim. Developing extrinsic, MTF/TRO/MCSC level incentives is only one enabler toward this end. MTFs and TROs are encouraged to think more broadly in their Performance Plans.
- Different pilots may focus on different areas. Such and focus and the rationale for the focus should be described in the individual Performance Plans.
- For inpatient and specialty care in particular, the rewards for more complex care is manifested in higher payment rates built into the reimbursement
- PCMH levels are based on meeting the criteria described in the NCQA PPC-PCMH Standards. NCQA has defined three levels of recognition for the PCMH. To be rated at Level 1, a practice must have an overall score of 25-49 points and at least a 50% score on five of the must-pass elements. Level 2 requires 50-74 points and at least a 50% score on all ten must-pass elements. Level 3 requires 75-100 points and at least a 50% score on all ten must-pass elements.
- Gray indicates that the activity will not be a focus for the Year 1 pilots

Pilot Sites


6
Madigan
West, Army, Hospital, Mult-Service Market
NORTH
4
Fort Carson
West, Army, Small Hospital, High Troop Population
2
Fort Campbell
North, Army, Small Hospital, High Troop Population
1
Quantico
North, Navy, Large Clinic, Robust MCSC Network
5
Luke
West, Air Force, Large Clinic
WEST
7
Keesler
South , Air Force, MedCen
3
Pensacola
South, Navy, Large Hospital Clinic, Robust MCSC Network
SOUTH
Army
Navy
Air Force

Notional Performance Improvement Matrix

Section 3 of Proposed Performance Plan Template

3. Performance Improvement Plan

Table 2 highlights the performance gaps on which we will focus, the initiatives that are intended to improve performance, and the performance adjustment that may be earned as a result of meeting the targets.

Table 2: Performance Improvement Matrix

Quadruple Aim	Strategic Imperative	Performance Measure	Our Current Perf.	MHS Target (FY10)	Our Target	Initiative	Performance Based Adjustment*
Readiness	Individual Medical Readiness	Individual Medical Readiness	80%	80%	8[illegible]		YES
	Psychological Health	Psychological Distress Screens, Referral and Engagement	-	-			
Experience of Care	Wounded Warrior Care	MEBs Completed Within 30 Days	80%	80%	8[illegible]		
		MEB Experience Rating	50%	45%	50%		
		Effectiveness of Care for Complex Medical / Social Problems	-	-	-		
	24/7 Access to Your Team	Getting Needed Care Rate	59%	78%	65%	(1) NCQA [illegible]tation	
		Getting Timely Care Rate	61%	78%	67%	(1) [illegible]ation; (3) Secure Messaging	
	Personal Relationship with Your Doctor	Percent of Visits Where MTF Enrollees See Their PCM	44%	60%	58%	(1) NCQA Level 2 Accreditation	YES
		Satisfaction with Health Care	51%	60%	58%	(1) NCQA Level 2 Accreditation	YES
	Evidence Based Care	ORYX Index	83%	80%	83%		YES
		HEDIS – Adhering to CPGs	19	20	21	(1) NCQA Level 2 Accreditation	YES
Population Health	Engaging Patients in Healthy Behaviors	HEDIS – Preventive Screens				(1) NCQA Level 2 Accreditation	YES
		Percent of Patients Advised to Stop Smoking	-	-			
Per Capita Cost	Value Based Incentives and Reimbursements	Annual Increase in Cost Per Equivalent Life (PMPM)	8.3%	6.0%	[illegible]%		YES
		Enrollee Utilization of Emergency Services	73	69	[illegible]0	(1) NCQA Level 2 Accreditation; (3) Secure Messaging	YES
		Impact of Deployment on MTFs	-	-			
Learning & Growth	Deliver information to People so They Can Make Better Decisions	User Assessment of EHR Functionality	-	-			
	Using Research to Improve Performance		-	-			
	Fully Capable MHS Workforce		-	-	-		

Current performance of pilot site

MHS Target

Target Performance of Pilot Site

Financial Incentive Included in Pilot

Not included in reimbursement methodology

Issues to Consider

- All MTFs need to Ensure Timely data submission
- Professional Services
  - Professional services should be coded this year for Inpatient
    - Approximately 80% complete (20% lost value)
    - Began 1 Oct 2002
  - Accurate coding
    - Ensure proper coding for services
    - Need to ensure coding matches documentation
    - Eventually audit adjustments to claims
- Non Provider specialty codes (Generic Clinics)
  - Last year workload accepted was FY06
  - FY07 forward no workload credit
- Treatment of Enrollees
  - Quality payments will rely on accurate identification of Enrollees
  - Documentation of treatment for Preventive Services
- Workload Trending
  - Budget Neutrality Factor used for CY06 and earlier

Questions?

Back Up Slides

IME Factors

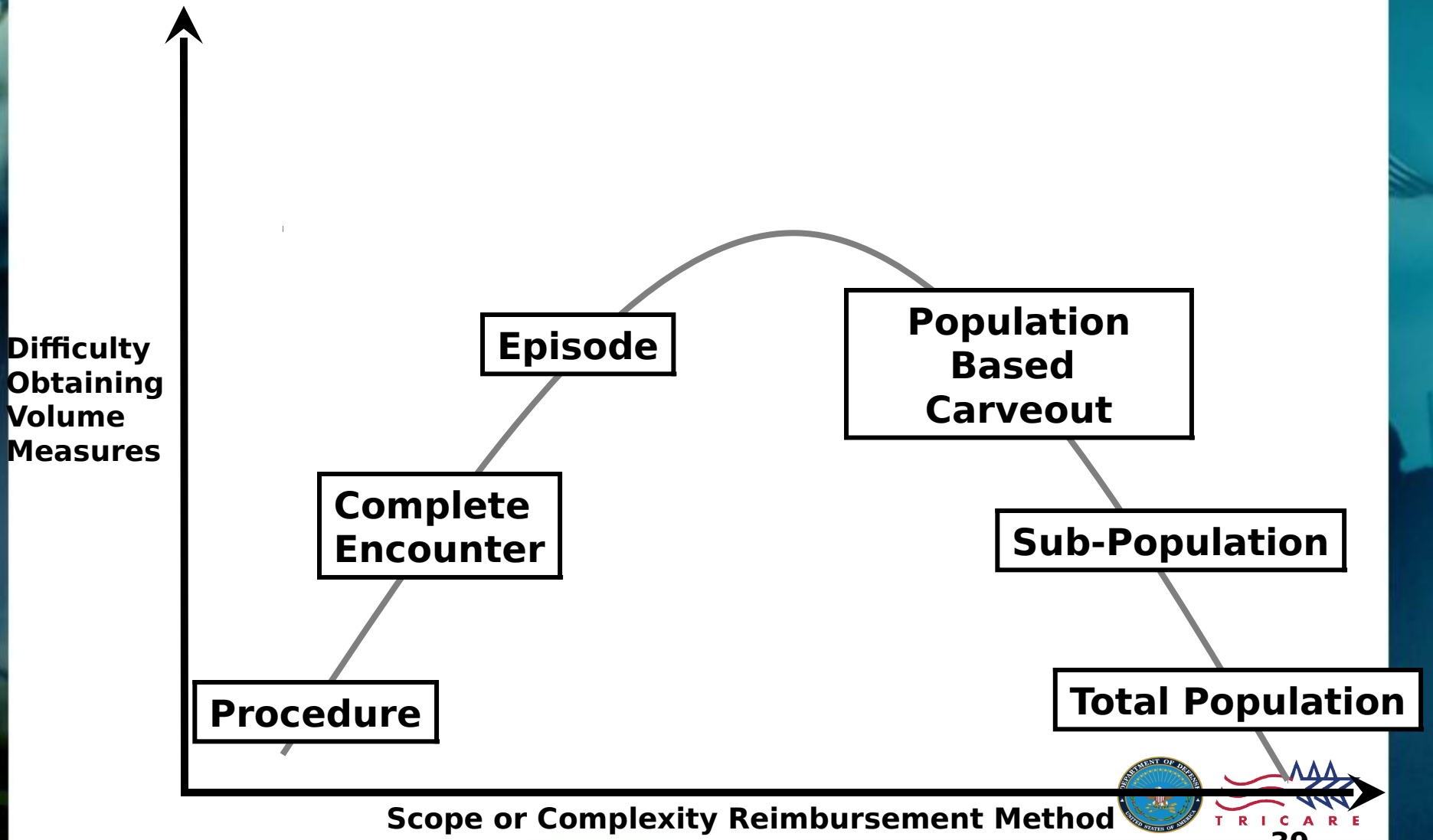
DMIS	Name	FY02	FY03	FY04	FY05	FY06	FY07	FY09	FY10
0014	DAVID GRANT	1.4141	1.3765	1.5737	**1.5996**	**1.6313**	**1.5676**	**1.3485**	**1.2930**
0024	PENDLETON	1.2895	1.1860	1.1681	**1.1848**	**1.1828**	**1.1739**	**1.1304**	**1.1476**
0029	SAN DIEGO	1.6415	1.5067	1.5067	**1.5173**	**1.4929**	**1.4588**	**1.4554**	**1.5370**
0037	WALTER REED	1.5849	1.5175	1.5265	**1.5523**	**1.5368**	**1.5824**	**1.5061**	**1.6961**
0038	PENSACOLA	1.2692	1.2269	1.2269	**1.2302**	**1.1938**	**1.1713**	**1.2092**	**1.2045**
0039	JACKSONVILLE	1.3484	1.2954	1.2911	**1.2944**	**1.2866**	**1.2669**	**1.2690**	**1.2086**
0042	EGLIN	1.2544	1.2801	1.3120	**1.3202**	**1.2622**	**1.1859**	**1.1928**	**1.2346**
0047	EISENHOWER	1.2772	1.2216	1.2208	**1.2318**	**1.2096**	**1.2352**	**1.2031**	**1.2249**
0048	MARTIN	1.2230	1.1733	1.1462	**1.1547**	**1.1477**	**1.1422**	**1.1408**	**1.1498**
0052	TRIPLER	1.3792	1.3249	1.3319	**1.3482**	**1.3987**	**1.3813**	**1.4400**	**1.4859**
0055	SCOTT	1.3377	1.2983	1.3119	**1.3034**	**1.2689**	**1.2554**	**1.0000**	**1.0000**
0066	MALCOLM GROW	1.3646	1.3306	1.3898	**1.4492**	**1.4366**	**1.4199**	**1.3663**	**1.2949**
0067	BETHESDA	1.6914	1.5430	1.5413	**1.4705**	**1.4139**	**1.3984**	**1.3493**	**1.3882**
0073	KEESLER	1.4844	1.3613	1.2533	**1.4352**	**1.4806**	**1.0000**	**1.0737**	**1.0737**
0078	EHRLING BERGQUIST	1.3313	1.3286	1.3961	**1.5929**	**1.3220**	**1.0000**	**1.0000**	**1.0000**
0086	KELLER	1.0114	1.0309	1.0417	**1.0398**	**1.0394**	**1.0372**	**1.0379**	**1.0394**
0089	WOMACK	1.1396	1.1176	1.1254	**1.1259**	**1.1187**	**1.1460**	**1.1425**	**1.1471**
0091	LEJEUNE	1.0000	1.0000	1.0000	**1.0621**	**1.0604**	**1.0976**	**1.0637**	**1.0548**
0095	WRIGHT-PATTERSON	1.6438	1.6523	1.7406	**1.6789**	**1.6153**	**1.5976**	**1.3764**	**1.4453**
0108	WILLIAM BEAUMONT	1.2425	1.1995	1.1971	**1.2033**	**1.2267**	**1.2041**	**1.2129**	**1.2461**
0109	BROOKE	1.5289	1.4459	1.4553	**1.4776**	**1.4565**	**1.4353**	**1.4474**	**1.5329**
0110	DARNALL	1.1182	1.0996	1.0996	**1.1035**	**1.0977**	**1.0914**	**1.0987**	**1.0932**
0117	WILFORD HALL	1.5818	1.4904	1.6006	**1.6300**	**1.5887**	**1.5694**	**1.5887**	**1.6467**
0123	DEWITT	1.2275	1.1883	1.1883	**1.1942**	**1.1920**	**1.2071**	**1.1974**	**1.2011**
0124	PORTSMOUTH	1.3389	1.3066	1.3066	**1.3216**	**1.3126**	**1.3005**	**1.2684**	**1.3324**
0125	MADIGAN	1.6389	1.5363	1.5630	**1.5438**	**1.4788**	**1.4499**	**1.4534**	**1.4947**
0126	BREMERTON	1.1716	1.1701	1.1817	**1.1902**	**1.2009**	**1.1977**	**1.1858**	**1.1783**

Value of 1.0 is used if there is no IME to zero out calculation in reconciliation.

Value of External Workload

Sum of Total $			FY FM				
			2008				
Service	Tmt DMIS	Tmt DMIS ID Name	1	2	3	4	5
A	2001	AUGUSTA VET ADMIN MED CTR	4,350	3,593	3,052	2,410	
	5434	SAMARITAN MEDICAL CENTER	81,363	72,418	70,247	60,728	
	5435	CARTHAGE AREA HOSPITAL	841	388	478		
A Total			86,554	76,399	73,777	63,138	
F	5467	TAMPA GEN HOSPITAL (CIVILIAN)	17,054	19,060	7,524		
	5468	TAMPA BAY SURG CENTER-CIVILIAN	3,009	6,520	3,009		
	5469	DELL E. WEBB MEM HOSP-CIVILIAN	5,081	8,336	2,741	4,378	
	5470	BANNER ESTRELLA MED CNTR-CIVLN	21,490	18,900	14,780	19,516	
F Total			46,633	52,815	28,053	23,894	
N	2002	NORTH CHICAGO VETERANS MED CTR	41,795	53,969	32,007	7,836	
	5401	NEWPORT HOSPITAL (CIVILIAN)	32,793	19,789	28,216	19,231	
	5402	TRIDENT REGIONAL MEDICAL CTR	77,897	75,629	60,325	45,729	
	5405	SPOHN HC SYS-CORPUS CHRISTI	32,476	29,321	25,244	43,282	2,422
	5407	BEAUFORT MEMORIAL HOSPITAL	23,740	33,675	36,463	2,577	
	5408	ANNE ARUNDEL MEDICAL CENTER (CIVILIAN)	13,140	8,153	6,359		
	5410	SACRED HEART HOSPITAL	397	397	79		
N Total			222,239	220,933	188,694	118,655	2,422
Grand Total			355,426	350,148	290,524	205,687	2,422

Reimbursement Approaches



Parameters

- Boundaries
  - What's in, what's out
- Risk Adjustment
  - Weighting based on expected differences
- Rate
  - Prospective Payment
- Catastrophic Cases
  - Treatment of outliers
- Quality
  - Rewards for experience of care and population health

Strawman

	Funding Approaches	Boundaries	Risk Adjustment	Rate	Catastrophic Cases	Possible Quality Adjustment
1	Readiness	MENBA Activities	None	FFS	None	Indeterminate IMR
2	Wellness	Beneficiary Behavior Activites	None	FFS	None	Healthy behavior measures
3	Prevention	Prevention activities such as mammographies	None	FFS based on RVUs	None	HEDIS
4	Primary Care	Excluding prevention activities and specific populations	None	FFS based on RVUs	None	Access, Sat, ER use, continuity, etc
5	Operating as a PCMH	Management of enrolled population	Age/Gender	Management fee	None	PCMH Standards
6	Specific Populations: Chronic Disease	All care for specific population related to disease	Stages of Disease	PC + Condition capitation	>$150 K	HEDIS/ORYX
7	Specific Populations: Acute Conditions	Specific to condition	Condition Specific	Episode Payment	>$25 K	Episode specific Outcomes
8	Other specialty	Excluding any care in 2-7	None	FFS	None	
9	Other inpatient	Excluding any care in 2-7	None	FFS	None	ORYX
10	Managing per capita costs	All care to an enrolled population	None	None	None	PMPM

Possible MTF Value Structure for Pilot

MTF Value =

+ FFS Rate X # Dental exams and PHAs + IMR P4P

+ FFS Rate X # of preventive services + HEDIS P4P

+ FFS rate X primary care RVUs + Sat/Access/Continuity/HEDIS P4P

+ Management fee (Based on PCMH Standards) X # of enrollees

+ FFS rate X other ambulatory RVUs/APCs

+ FFS rate X other inpatient RWPs/Beddays + ORYX P4P

+/- Adjustment for performance on Per Capita Costs

- Budget Neutrality for the MHS may results in decreases to RVU/RWP payments

Industry Standard Workload

- Inpatient/Outpatient vs. Institutional/Professional
- Industry Based Workload Alignment (IBWA)
  - Rounds capture 2yrs old (appx 80% complete)
  - Full Inpatient professional workload capture began last year
  - Enhanced SADR (Standard Provider ID plus Modifiers)
  - Would allow PPS value to follow more closely TMAC
  - Would allow credit for professional work done away from facility
    - External Resource Sharing
    - Circuit Riders
    - Joint Facilities
- Full RVU vice Simple Work RVU

FY08 Summary Quality Payment

	HEDIS	ORYX	Plan	Care	Comm	Access	Total
Army	$ 2,092	$ 558	$ 5,400	$ 4,621	$ 5,795	$ 2,612	$ 21,078
Air Force	$ 1,230	$ 517	$ 6,230	$ 2,062	$ 4,481	$ 4,458	$ 18,978
Navy	$ 1,563	$ 710	$ 2,038	$ 4,154	$ 4,795	$ 1,278	$ 14,538
Total	$ 4,885	$ 1,785	$ 13,668	$ 10,837	$ 15,071	$ 8,348	$ 54,594

Initial FY09 Proposed P4P Payment

Measures	Value Range
HEDIS	$18M-$25M
ORYX	$1M
Health Plan	$8M-$10M
Health Care	$5M
Communication	$12M
Needed Care	$7M-$14M
PCM Appt	$4M-$8M
Total	$55M-$75M

- Due to Funding issues there was not an adjustment for FY09

MENBA Pilot Project

- **QDR: "Capture the quantity, value, and expense of readiness and military-unique services provided by MHS activities"**
- Identify and List all Mission Essential/Non-Benefit Activities (MENBA) performed in the MHS
- On-site visits
  - 6 MTFs (1 small & 1 Large from each Service)
  - MTF Participation:
    - Coordinate Schedule
    - Provide limited Documents (e.g., Committees List, Additional Duties Rosters, etc.)
    - Be Part of the Team, Part of the Project!
- Work with MENBA WG to "sort out", classify & develop Taxonomy for activities

Project Update

- MENBA WG has met multiple times
- Several meetings with Altarum & Project Lead
- All Services have Identified MTFs & POCs
- All MTFs are done
  - Seymour Johnson AFB, Travis AFB, Pendleton MCB, Ft Benning, Ft Hood, NNMC Bethesda
- Specialty working groups reviewed activities
  - First meetings in April/May
  - Reviewed information to see what activities should be MENBA
  - Future work will included how to value and report

Working MENBA List (Working Activity Classes*)

IMR/DNBI Prevention/Occupational Health	Approved NonBenefit Clinical Activity	Military Unique Clnical Activity	Military Unique NonClinical Activity	Deployment Readiness	Military Unique Training	GME/GDE
Base agency support	Health Prom (HP)/Adm	Aeroevac	Activity Support	Administration	Commanders Call	GDE
Base Meetings	HP/Classes	Ambulance Support	Additional Duties	Base Support	Communication	GME/GDE Adm
Deployment/Preparation	HP/Communication	Appointments	Agency support	Communications	Conference	GME/Prog Directors
Deployment/During	HP/Evaluation	Backfill	Ceremony	Deployment/Adm	Exercise Trg	GME/Residents
Deployment/After	HP/AD Fitness	Blood Program	Commander	Deployment/Mobility	First Term Enlisted	GME/Med Students
Drug screening	HP/HAWC	Boards	Community	Deployment/Response	Fitness	GME/Teaching Staff
First Aid	HP/Health Fairs	Call	Compliance Program	Exercises	Job Specific	
Immunizations	HP/Health Month	Clinical Investigations	Decedent	Homeland Security	Leadership Dev	
IMR program	HP/Pop Health	Care	Ethics	Humanitarian Mission	Pop Health	
JUMPSTART	HP/Screening	Clinical Networks	Food Service	Logistics/WRM	Readiness Trg/CBRNE	
Medical Right Start	Vision Correction	Inspections	Legal	NDMS	Readiness Trg/Core Specific	
Occup Health/Adm		Dental	Logistics	Plans	Readiness Trg/Envi	
Occup Health/HazMat		Diagnostics & Therapeutics	Information Services	Team	Readiness Tng/Ordinance	
Occup Health/Hearing		Family Advocacy	MOU/MOA	Threat	Readiness Trg/Rescue	
Occup Health/Safety		Flight Medicine/ Line Consultation	Orderly room		Readiness Trg/Rules	
Occup Health/Screening		Flight Medicine/ Operational Med	Patient Adm TRICARE		Readiness Trg/Terriorism	
Occup Health/Radiation		Flight Medicine/ Deployment Medicine	Plant Management		Readiness Trg/Unit	
Occup Health/Respiratory		Flight Medicine/ Disaster Response	Protocol		Reservists	
Occup Health/Water		Hyperbaric Medicine	Public Affairs		Safety	
Physiological Training		Life Skills	Resource Management			
Public/Env Health/Adm		Medical Management	Vehicle Progam			
Public/Env Health/Emp Health		Nursing				
Public/Env Health/HIV		Patient relations				
Public/Env Health/Screening		Pharmacy				
Public/Env Health/Surveillance		PRP				
Public/Env Health/STD		Profiles				
Public/Env Health/TB		QA/Crendentials				
Veterinary Prog/Animal		Screening				
Veterinary Prog/Food		Supervision				
Veterinary Prog/Vector		Support				
		Training				
		Volunteers				
Total 483	Total 115	Total 369	Total 369	Total 184	Total 152	Total 110

*As of 5 Feb 2007

Mission Essential Non-Benefit Activities (MENBA)

- **QDR: "Capture the quantity, value, and expense of readiness and military-unique services provided by MHS activities"**
  - √ Identify and List all Mission Essential/Non-Benefit Activities (MENBA) performed in the MHS
  - √ Classify & develop Taxonomy for activities
  - – Measure volume of activities
  - – Develop "value"
  - – Incorporate into budget process

MENBA Current Study

Occupational Health/Public Health

Health Promotion & Wellness

Military Unique Clinical

Military Unique Non-Clinical

Readiness, Plans, Ops & Deployment

GME & GDE

Military Unique Training

127 Activity Groups

Wide spread/ Universal | **Chance of Success** | **Importance** | **Resource Utilization** | **Volume**

4 Activity Groups for current study

Disability Evaluation System (“Boards”)

Hearing Conservation/ Hearing Program

Patient Movement

Health Education

Next Steps – Longer Term

- Expand RBRVS to cover as many of the MENBA activities as possible
- Incorporate MENBA RBRVS into budget process
  - Build into Business Plans
  - Justify/adjust MTF budgets based on value of activities produced